

		FOR OHF USE					

LL 1

**2002**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2002)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH Facility ID Number:</b> <u>0008201</u></p> <p><b>Facility Name:</b> <u>Du Page Convalescent Center</u></p> <p><b>Address:</b> <u>400 North County Farm Road</u> <u>Wheaton</u> <u>60187</u>          Number City Zip Code</p> <p><b>County:</b> <u>Du Page</u></p> <p><b>Telephone Number:</b> <u>(630) 665-6400</u> <b>Fax #</b> <u>(630) 665-2446</u></p> <p><b>IDPA ID Number:</b> <u>36-6006551-002</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>Prior to 1935</u></p> <p><b>Type of Ownership:</b></p> <table> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input checked="" type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input checked="" type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Patrick Szajkovics</u> <b>Telephone Number:</b> <u>(847) 259-7373, Ext. 111</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input checked="" type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>Dec. 1, 2001</u> to <u>Nov. 30, 2002</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table> <tr> <td data-bbox="1150 678 1283 829" rowspan="2"><b>Officer or Administrator of Provider</b></td> <td data-bbox="1283 678 1923 711">(Signed) _____ <u>3/31/2003</u> (Date)</td> </tr> <tr> <td data-bbox="1283 711 1923 743">(Type or Print Name) <u>Beth Welch</u></td> </tr> <tr> <td data-bbox="1150 743 1283 808" rowspan="2"></td> <td data-bbox="1283 743 1923 808">(Title) <u>Administrator</u></td> </tr> <tr> <td data-bbox="1150 808 1283 878" rowspan="4"><b>Paid Preparer</b></td> <td data-bbox="1283 808 1923 841">(Signed) _____ <u>3/31/2003</u> (Date)</td> </tr> <tr> <td data-bbox="1283 841 1923 878">(Print Name and Title) <u>Patrick Szajkovics</u> <u>Consultant</u></td> </tr> <tr> <td data-bbox="1283 878 1923 911">(Firm Name &amp; Address) <u>Strategic Reimbursement, Inc.</u> <u>3315 W. Algonquin Rd. S. 110 Rolling Meadows, IL 60008</u></td> </tr> <tr> <td data-bbox="1283 911 1923 943">(Telephone) <u>(847) 259-7373</u> <b>Fax #</b> <u>(847) 259-9869</u></td> </tr> <tr> <td colspan="2" data-bbox="1150 1040 1923 1131"> <p><b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b></p> </td> </tr> </table>	<b>Officer or Administrator of Provider</b>	(Signed) _____ <u>3/31/2003</u> (Date)	(Type or Print Name) <u>Beth Welch</u>		(Title) <u>Administrator</u>	<b>Paid Preparer</b>	(Signed) _____ <u>3/31/2003</u> (Date)	(Print Name and Title) <u>Patrick Szajkovics</u> <u>Consultant</u>	(Firm Name & Address) <u>Strategic Reimbursement, Inc.</u> <u>3315 W. Algonquin Rd. S. 110 Rolling Meadows, IL 60008</u>	(Telephone) <u>(847) 259-7373</u> <b>Fax #</b> <u>(847) 259-9869</u>	<p><b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b></p>	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" type="checkbox"/> GOVERNMENTAL																																			
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																			
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input checked="" type="checkbox"/> County																																			
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																																			
	<input type="checkbox"/> "Sub-S" Corp.																																				
	<input type="checkbox"/> Limited Liability Co.																																				
	<input type="checkbox"/> Trust																																				
	<input type="checkbox"/> Other _____																																				
<b>Officer or Administrator of Provider</b>	(Signed) _____ <u>3/31/2003</u> (Date)																																				
	(Type or Print Name) <u>Beth Welch</u>																																				
	(Title) <u>Administrator</u>																																				
	<b>Paid Preparer</b>	(Signed) _____ <u>3/31/2003</u> (Date)																																			
(Print Name and Title) <u>Patrick Szajkovics</u> <u>Consultant</u>																																					
(Firm Name & Address) <u>Strategic Reimbursement, Inc.</u> <u>3315 W. Algonquin Rd. S. 110 Rolling Meadows, IL 60008</u>																																					
(Telephone) <u>(847) 259-7373</u> <b>Fax #</b> <u>(847) 259-9869</u>																																					
<p><b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b></p>																																					

## STATE OF ILLINOIS

Page 2

Facility Name & ID Number Du Page Convalescent Center# 0008201 Report Period Beginning: Dec. 1, 2001 Ending: Nov. 30, 2002

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>508</u>	Skilled (SNF)	<u>508</u>	<u>185,420</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>508</u>	TOTALS	<u>508</u>	<u>185,420</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>112,398</u>	<u>28,746</u>	<u>11,927</u>	<u>153,071</u>	8
9	SNF/PED					9
10	ICF	<u>1,660</u>	<u>0</u>	<u>0</u>	<u>1,660</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>114,058</u>	<u>28,746</u>	<u>11,927</u>	<u>154,731</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 83.45%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)Meals on Wheels, Empl. Meals, Empl. Pharmacy, Empl. Therapy, County Laundry

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☒NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started PRE-1935

J. Was the facility purchased or leased after January 1, 1978?

YES ☐Date                     NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 50 and days of care provided 10,025Medicare Intermediary Mutual of Omaha Insurance Company

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 11/30/2002 Fiscal Year: 11/30/2002

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number Du Page Convalescent Center

# 0008201

Report Period Beginning: Dec. 1, 2001

Ending: Nov. 30, 2002

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	1,663,284	171,719	16,969	1,851,972		1,851,972	(522,287)	1,329,685		1
2	Food Purchase		1,314,311		1,314,311		1,314,311	(370,658)	943,653		2
3	Housekeeping	1,063,462	195,896	61,389	1,320,747		1,320,747	(114,672)	1,206,075		3
4	Laundry	267,510	111,538	251,965	631,013		631,013	(1,092)	629,921		4
5	Heat and Other Utilities			1,380,013	1,380,013		1,380,013		1,380,013		5
6	Maintenance			1,012,142	1,012,142		1,012,142	(86,664)	925,478		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	2,994,256	1,793,464	2,722,478	7,510,198		7,510,198	(1,095,373)	6,414,825		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	11,923,776	626,521	1,132,110	13,682,407	(532,106)	13,150,301		13,150,301		10
10a	Therapy	589,141	12,729	20,540	622,410	(2,528)	619,882	201,346	821,228		10a
11	Activities	541,478	22,685	698	564,861		564,861		564,861		11
12	Social Services	410,441	1,167	2,156	413,764		413,764		413,764		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	13,464,836	663,102	1,155,504	15,283,442	(534,634)	14,748,808	201,346	14,950,154		16
	<b>C. General Administration</b>										
17	Administrative	182,725		715,981	898,706		898,706		898,706		17
18	Directors Fees										18
19	Professional Services			129,198	129,198		129,198		129,198		19
20	Dues, Fees, Subscriptions & Promotions			33,936	33,936		33,936	(20,038)	13,898		20
21	Clerical & General Office Expenses	1,167,621	110,205	251,385	1,529,211		1,529,211	(10,328)	1,518,883		21
22	Employee Benefits & Payroll Taxes			3,618,048	3,618,048		3,618,048	55,123	3,673,171		22
23	Inservice Training & Education										23
24	Travel and Seminar			46,523	46,523		46,523	(2,092)	44,431		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			388,189	388,189		388,189		388,189		26
27	Other (specify):* <b>Bad Debt Expense</b>			194,502	194,502		194,502	(194,502)			27
28	<b>TOTAL General Administration</b>	1,350,346	110,205	5,377,762	6,838,313		6,838,313	(171,837)	6,666,476		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	17,809,438	2,566,771	9,255,744	29,631,953	(534,634)	29,097,319	(1,065,864)	28,031,455		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name &amp; ID Number

Du Page Convalescent Center

#0008201

Report Period Beginning:

Dec. 1, 2001

Ending:

Nov. 30, 2002

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			1,408,024	1,408,024		1,408,024		1,408,024			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,408,024	1,408,024		1,408,024		1,408,024			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	343,960	1,484,345	18,552	1,846,857	534,634	2,381,491	(6,697)	2,374,794			39
40	Barber and Beauty Shops	123,596			123,596		123,596		123,596			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							278,130	278,130			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>	467,556	1,484,345	18,552	1,970,453	534,634	2,505,087	271,433	2,776,520			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	18,276,994	4,051,116	10,682,320	33,010,430		33,010,430	(794,431)	32,215,999			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name &amp; ID Number Du Page Convalescent Center

# 0008201

Report Period Beginning:

Dec. 1, 2001

Ending:

Nov. 30, 2002

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(86,664)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(1,092)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,638)	20		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(16,400)	20		18
19	Entertainment	(2,092)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(194,502)	27		24
25	Fund Raising, Advertising and Promotional	(572)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Sch. 5A	(690,817)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (995,777)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	201,346	10a	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 201,346		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (794431)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program	X		532,106	10	44
45	Other-Attach Schedule Exc-Thpy	X		2,528	10a	45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 534,634		47

Du Page Convalescent Center

ID# 0008201

Report Period Beginning: Dec. 1, 2001

Ending: Nov. 30, 2002

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Employee Reimbursements - Other Ancillary	\$ (6,697)	39	1
2	Cafeteria Income - Food	(74,074)	2	2
3	Cafeteria Income - Other costs	(104,376)	1	3
4	Catering and 421 Cafeteria - Food	(296,584)	2	4
5	Catering and 421 Cafeteria - Other costs	(417,911)	1	5
6	Provider Participation Fee	278,130	42	6
7	County expense benefits allocation	55,123	22	7
8	Other Miscellaneous revenues	(9,756)	21	8
9	West Campus Cleaning revenues	(114,672)	3	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(690,817)		49

## STATE OF ILLINOIS

## Summary A

Facility Name &amp; ID Number Du Page Convalescent Center

# 0008201

Report Period Beginning:

Dec. 1, 2001

Ending:

Nov. 30, 2002

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	(522,287)	0	0	0	0	0	0	0	0	0	0	(522,287)	1
2	Food Purchase	(370,658)	0	0	0	0	0	0	0	0	0	0	(370,658)	2
3	Housekeeping	(114,672)	0	0	0	0	0	0	0	0	0	0	(114,672)	3
4	Laundry	(1,092)	0	0	0	0	0	0	0	0	0	0	(1,092)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(86,664)	0	0	0	0	0	0	0	0	0	0	(86,664)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,095,373)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,095,373)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	201,346	0	0	0	0	0	0	0	0	0	0	201,346	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>201,346</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>201,346</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(20,038)	0	0	0	0	0	0	0	0	0	0	(20,038)	20
21	Clerical & General Office Expenses	(10,328)	0	0	0	0	0	0	0	0	0	0	(10,328)	21
22	Employee Benefits & Payroll Taxes	55,123	0	0	0	0	0	0	0	0	0	0	55,123	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,092)	0	0	0	0	0	0	0	0	0	0	(2,092)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(194,502)	0	0	0	0	0	0	0	0	0	0	(194,502)	27
28	<b>TOTAL General Administration</b>	<b>(171,837)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(171,837)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(1,065,864)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,065,864)</b>	<b>29</b>



Facility Name &amp; ID Number Du Page Convalescent Center

# 0008201

Report Period Beginning:

Dec. 1, 2001

Ending:

Nov. 30, 2002

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
NONE						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	10a Physical Therapy	\$ 821,655	Marianjoy Rehab - Joint Venture	50.00%	\$ 441,125	\$ (380,530)
2	V	10a Speech Therapy	1	Marianjoy Rehab - Joint Venture	50.00%	159,191	159,190
3	V	10a Occup Therapy	1,923	Marianjoy Rehab - Joint Venture	50.00%	424,609	422,686
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 823,579			\$ 1,024,925	\$ * 201,346

\* Total must agree with the amount recorded on line 34 of Schedule VI.

## STATE OF ILLINOIS

Page 7

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2001 Ending: Nov. 30, 2002

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NONE								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Du Page Convalescent Center# 0008201

Report Period Beginning:

Dec. 1, 2001

Ending: Nov. 30, 2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Du Page County GovernmentStreet Address 421 N. County Farm Road (Finance Dept.)City / State / Zip Code Wheaton, Illinois 60187Phone Number ( 630) 682-7449Fax Number ( 630) 682-7964

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	I.M.R.F & Social Security	Direct Cost	14,466,384	\$ 14,466,384	\$ 0	1,523,362	\$ 1,523,362	1
2	22	Employee Medical	Direct Cost	6,441,269	6,441,269	0	55,123	55,123	2
3	20	Statutory & Fiscal	Direct Cost	34,875	34,875	0	25	25	3
4	19	Finance & Auditor	# of A/P Claims	66,886	515,314	270,868	11,157	85,958	4
5	19	County Audit	% of Time Spent	100	201,482	0	4	8,059	5
6	19	General Acctg & Budget	% of All Depts	52	957,871	461,919	1	18,421	6
7	21	Mail Delivery	Wtd Avg # of Del	250,000	250,000	205,932	5,396	5,396	7
8	22	Workers Comp Claims	Direct Cost	1,044,081	1,044,081	0	206,762	206,762	8
9	22	Workers Comp Premiums	# of Claims	254,762	254,762	0	47,295	47,295	9
10	26	Property Insurance	Building Value	100,000	291,334	0	9,547	27,814	10
11	26	Gen & Prof Liab / Surety Bd	Direct Cost	1,276,787	1,276,787	0	339,862	339,862	11
12	22	Unemployment Comp Ins	Direct Cost	111,053	111,053	0	22,859	22,859	12
13	26	Service Retention Fee	# of Ins Claims	233	75,860	0	63	20,511	13
14	17	Maint of Grounds	Square Footage	582,183	582,183	309,012	92,394	92,394	14
15	5	Utilities, Space & HVAC	Square Footage	8,447,959	8,447,959	584,008	1,048,965	1,048,965	15
16	17	Security	Square Footage	917,194	917,194	594,536	226,327	226,327	16
17	6	Building Maintenance	Direct Cost	2,766,464	2,766,464	191,246	1,004,623	1,004,623	17
18	21	Telecomm	Direct Cost	1,154,896	1,154,896	0	414	414	18
19	6	Rental of Equip	Direct Cost	33,174	33,174	0	994	994	19
20	6	Repair & Maint of Equip	Direct Cost	91,177	91,177	0	6,525	6,525	20
21	17	Personnel Costs	% of Ads & FTEs	1,987,960	1,987,960	1,221,389	425,027	425,027	21
22	17	Purchasing Costs	# of Purchase Orders	667,796	667,796	378,692	40,264	40,264	22
23	17	County Board	Comm Assignmnts	1,043,116	1,043,116	1,043,116	19,794	19,794	23
24	17	County Administrator	Dept Size	76,000	76,000	76,000	4,000	4,000	24
25	TOTALS				\$ 43,688,991	\$ 5,336,718		\$ 5,230,774	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1	N/A						\$		\$			\$		1					
2														2					
3														3					
4														4					
5														5					
	Working Capital																		
6	N/A													6					
7														7					
8														8					
9	TOTAL Facility Related							\$		\$			\$		9				
	B. Non-Facility Related*																		
10	N/A													10					
11														11					
12														12					
13														13					
14	TOTAL Non-Facility Related							\$		\$			\$		14				
15	TOTALS (line 9+line14)							\$		\$			\$		15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **Du Page Convalescent Center**# **0008201** Report Period Beginning: **Dec. 1, 2001** Ending: **Nov. 30, 2002****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2001 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1997	8		
	1998	9		
	1999	10		
	2000	11		
	2001	12		
			<b>FOR OHF USE ONLY</b>	
			13	FROM R. E. TAX STATEMENT FOR 2001 \$ 13
			14	PLUS APPEAL COST FROM LINE 5 \$ 14
			15	LESS REFUND FROM LINE 6 \$ 15
			16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2001 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Du Page Convalescent Center COUNTY Du Page

FACILITY IDPH LICENSE NUMBER 0008201

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE (     ) \_\_\_\_\_ FAX #: (     ) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>N/A</u>	<u>N/A</u>	\$ <u>          </u>	\$ <u>          </u>
2.	<u>          </u>	<u>          </u>	\$ <u>          </u>	\$ <u>          </u>
3.	<u>          </u>	<u>          </u>	\$ <u>          </u>	\$ <u>          </u>
4.	<u>          </u>	<u>          </u>	\$ <u>          </u>	\$ <u>          </u>
5.	<u>          </u>	<u>          </u>	\$ <u>          </u>	\$ <u>          </u>
6.	<u>          </u>	<u>          </u>	\$ <u>          </u>	\$ <u>          </u>
7.	<u>          </u>	<u>          </u>	\$ <u>          </u>	\$ <u>          </u>
8.	<u>          </u>	<u>          </u>	\$ <u>          </u>	\$ <u>          </u>
9.	<u>          </u>	<u>          </u>	\$ <u>          </u>	\$ <u>          </u>
10.	<u>          </u>	<u>          </u>	\$ <u>          </u>	\$ <u>          </u>
		<b>TOTALS</b>	\$ <u>          </u>	\$ <u>          </u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES        NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

A. Square Feet:

257,371

B. General Construction Type:

Exterior

Masnry Reinf Concr

Frame

Steel

Number of Stories

5

C. Does the Operating Entity?

X

(a) Own the Facility

(b) Rent from a Related Organization.

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

X

(a) Own the Equipment

(b) Rent equipment from a Related Organization.

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

YES

X

NO

If so, please complete the following:

1. Total Amount Incurred:

N/A

2. Number of Years Over Which it is Being Amortized:

N/A

3. Current Period Amortization:

N/A

4. Dates Incurred:

N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility Bldgs	400,000	Various	\$ 784,360	1
2					2
3	TOTALS	400,000		\$ 784,360	3

Facility Name &amp; ID Number Du Page Convalescent Center

# 0008201

Report Period Beginning:

Dec. 1, 2001 Ending: Nov. 30, 2002

**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Bed*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	288	1947	1947	\$ 70,858	\$	30	\$	\$	70,858
5			1964	1,172,064	34,473	34	34,473		675,088
6	104		1978	4,456,548	148,552	30	148,552		3,651,894
7	16		1979	1,750,524	58,351	30	58,351		1,351,795
8	100		1993	6,516,821	259,038	Various	259,038		2,365,505
<b>Improvement Type**</b>									
9	Mech Room renovation & heat exchangers		1976	44,372		20			44,372
10	Alarm Equip doors & other, Project 181		1977	8,545		20			8,545
11	Cyclone Dust Collector		1978	12,188		20			12,188
12	Flagpole		1979	844		20			844
13	Kitchen Door / Ground North remodel		1981	212,304		20			212,304
14	South Bldg renovation - Phase III (Per 1989 Adj)		1983	3,782,867	189,143	20	189,143		3,781,995
15	South Bldg renovation - Phase III - Architect Fees		1983	262,953	13,148	20	13,148		257,476
16	Laundry, 3-center & nurse station remodel		1985	261,742	9,947	15/20	9,947		231,898
17	Tubs & Parking lot projects		1989	199,883	9,994	20	9,994		129,093
18	Oxygen Manifold - North Bldg		1990	5,423	271	20	271		3,231
19	Ground North & Hydrotherapy remodel		1991	331,512	18,438	15/20/25	18,438		201,284
20	Window replacement, 3-Center & Nurse Station Remodel		1992	604,207	32,536	10/15/20/25	32,536		350,999
21	Laundry Water Heater & Softners, asphalt rep & landscape		1993	588,826	34,963	10/12/15/20	34,963		314,690
22	ADA & Elevator upgrades, Nurse Station remodel & misc		1994	105,577	6,634	5/10/15/20	6,634		58,928
23	Sewer Ejector pumps & Carpet replacement		1995	31,457	2,776	5/10	2,776		25,210
24	Carpet replace in Recreation & Volunteer areas & misc		1996	7,963		5			7,963
25	Chilled Water Bridges, Liquid Oxygen, Lights refit & Elevator		1997	320,587	18,808	5/10/20	18,808		102,098
26	Elevator Pit Ladders & automatic Entrance doors		1998	10,922	950	10/20	950		4,053
27	Lobby Remodel, Carpet, Elevator safety system & HVAC		1999	701,043	76,792	5/10/20	76,792		231,072
28	Tubs, Reception, Laundry, Kitchen Elev, HVAC & Access Eqp		2000	848,431	89,047	5/10/15/20	89,047		194,888
29	Tub Room Remodel, Life Safety Syst, Elev & Liq Oxygen Eqp		2001	473,208	47,321	10	47,321		48,479
30	Carpeting		2002	8,582	793	5	793		793
31	Roof Rehab, Card readers, & kitchen renovation		2002	219,254	3,760	10	3,760		3,760
32	Fire Alarm Dampers, System & Adminj		2002	1,515,449	37	10	37		37
33	Director Signage		2002	65,448	273	20	273		273
34	HVAC Modifications		2002	102,341		15			
35									
36									

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 24,692,743	\$ 1,056,045		\$ 1,056,045	\$	\$ 14,341,613	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,966,196	\$ 323,898	\$ 323,898		3/4/10	\$ 1,747,815	71
72	Current Year Purchases	400,834	27,914	27,914		3/4/10	27,694	72
73	Fully Depreciated Assets	1,197,227					1,197,227	73
74	Deletions	(35,390)	(15,153)	(15,153)		5	(33,810)	74
75	TOTALS	\$ 4,528,867	\$ 336,659	\$ 336,659	\$		\$ 2,938,926	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Snowplow & Maint/02 Van	Various/97 White ford van	Various/ 02	\$ 182,531	\$ 1,168	\$ 1,168		3/4/10	\$ 178,148	76
77	Grounds Maint	John Deere Tractor	11/99	12,685	1,269	1,269		10	4,758	77
78	Maint & Transport	Ford A-10 Van	11/00	38,971	9,743	9,743		4	23,545	78
79	Maint & Transport	2001 Window Van	11/01	31,396	3,140	3,140		10	3,140	79
80	TOTALS			\$ 265,583	\$ 15,320	\$ 15,320	\$		\$ 209,591	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 30,271,553	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,408,024	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,408,024	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 17,490,130	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ N/A Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$ \_\_\_\_\_

13. /2004 \$ \_\_\_\_\_

14. /2005 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln 10a, Col 8	4154 hrs	132,248				4,154	132,248	4
5	Physician Care	Ln 10, Col 8	visits		4,602	24,000		4,602	24,000	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Ln 39, Col 8	60997 # of prescrpts	343,960			3,537,816	60,997	3,881,776	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	Ln 39, Col 8		389,659			144,975		534,634	12
13	Other (specify):									13
14	TOTAL			\$ 865,867	4,602	\$ 24,000	\$ 3,682,791	69,753	\$ 4,572,658	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 288,591	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 500,000 )	4,487,137		3
4	Supply Inventory (priced at Cost )	336,194		4
5	Short-Term Investments	1,015,000		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,044		8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 6,127,966	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	784,360		13
14	Buildings, at Historical Cost	24,781,091		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,764,958		16
17	Accumulated Depreciation (book methods)	(17,452,020)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	338,935		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 13,217,324	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 19,345,290	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,047,494	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,095,939		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to Other Funds</u>	55,123		36
37	<u>Capital Lease &amp; Other Liab</u>	199,602		37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 2,398,158	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Accrued Empl Retention &amp; Vac/Sick</u>	613,268		43
44	<u>Capital Lease</u>	229,108		44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 842,376	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 3,240,534	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 16,104,756	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 19,345,290	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 16,401,187</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding diff</b>	<b>(1)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 16,401,186</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(6,579,366)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Unreconciled variance</b>	<b>1,049</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (6,578,317)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Contributed Capital</b>	<b>5,687,880</b>	<b>18</b>
<b>19</b>	<b>Donated Capital</b>	<b>594,007</b>	<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$ 6,281,887</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 16,104,756</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 24,098,319	1
2	Discounts and Allowances for all Levels	(3,956,848)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 20,141,471	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,334,684	6
7	Oxygen	164,276	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,498,960	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants	434,418	10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	(8)	13
14	Non-Patient Meals	892,945	14
15	Telephone, Television and Radio	86,664	15
16	Rental of Facility Space		16
17	Sale of Drugs	2,230,183	17
18	Sale of Supplies to Non-Patients	8,661	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	6,697	21
22	Laundry	1,092	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 3,660,652	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	15,309	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 15,309	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	West Campus Cleaning revenue	114,672	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 114,672	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 26,431,064	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	7,510,198	31
32	Health Care	15,283,442	32
33	General Administration	6,838,313	33
	<b>B. Capital Expense</b>		
34	Ownership	1,408,024	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	1,970,453	35
36	Provider Participation Fee		36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 33,010,430	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(6,579,366)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (6,579,366)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

## STATE OF ILLINOIS

Page 20

Facility Name &amp; ID Number Du Page Convalescent Center

# 0008201

Report Period Beginning: Dec. 1, 2001

Ending:

Nov. 30, 2002

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,409	2,688	\$ 162,966	\$ 60.63	1
2	Assistant Director of Nursing	1,502	1,621	93,362	57.60	2
3	Registered Nurses	139,366	156,200	4,247,712	27.19	3
4	Licensed Practical Nurses	29,239	32,400	696,592	21.50	4
5	Nurse Aides & Orderlies	427,660	479,585	6,319,557	13.18	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	15,397	17,531	476,207	27.16	7
8	Rehab/Therapy Aides	23,212	26,945	386,812	14.36	8
9	Activity Director	1,688	1,848	74,312	40.21	9
10	Activity Assistants	26,743	30,618	467,165	15.26	10
11	Social Service Workers	18,867	20,846	410,441	19.69	11
12	Dietician	7,394	8,384	154,570	18.44	12
13	Food Service Supervisor	4,918	5,358	111,134	20.74	13
14	Head Cook	3,839	4,202	68,395	16.28	14
15	Cook Helpers/Assistants	65,471	71,100	759,927	10.69	15
16	Dishwashers	60,059	63,256	569,258	9.00	16
17	Maintenance Workers					17
18	Housekeepers	85,396	93,888	1,063,463	11.33	18
19	Laundry	18,026	20,039	267,510	13.35	19
20	Administrator	1,490	1,849	98,851	53.46	20
21	Assistant Administrator	1,900	2,085	81,391	39.04	21
22	Other Administrative	13,864	15,417	400,257	25.96	22
23	Office Manager					23
24	Clerical	42,953	48,343	767,364	15.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,782	2,070	70,081	33.86	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,461	5,026	72,710	14.47	31
32	Other Health C: Nrs sect, W/C	20,170	22,394	333,361	14.89	32
33	Other(specify) Barber/Beauten	7,187	8,321	123,596	14.85	33
34	TOTAL (lines 1 - 33)	1,024,993	1,142,014	\$ 18,276,994 *	\$ 16.00	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	383	\$ 12,426	Ln 1, C 3	35
36	Medical Director				36
37	Medical Records Consultant	68	2,047	Ln 10, C 3	37
38	Nurse Consultant	267	13,350	Ln 10, C 3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	6,160	144,539	Ln 10a, C 3	40
41	Occupational Therapy Consultant	6,249	139,127	Ln 10a, C 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1,693	52,160	Ln 10a, C 3	43
44	Activity Consultant	12	624	Ln 11, C 3	44
45	Social Service Consultant	82	4,094	Ln 12, C 3	45
46	Other(specify) Medicare consultnt	237	8,541	Ln 21, C 3	46
47	Housekeeping Consultant	32	1,360	Ln 3, C 3	47
48	Social Work, PRN	933	29,971	Ln 10, C 3	48
49	TOTAL (lines 35 - 48)	16,116	\$ 408,239		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	994	\$ 52,164	Ln 10, C 3	50
51	Licensed Practical Nurses	373	14,265	Ln 10, C 3	51
52	Nurse Aides	462	9,788	Ln 10, C 3	52
53	TOTAL (lines 50 - 52)	1,829	\$ 76,217		53

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	%	Amount	Description		Amount	Description		Amount		
Beth Welch	Administrator	None	\$ 98,851	Workers' Compensation Insurance		\$ 254,056	IDPH License Fee		\$		
Mark Trnka	Asst. Adminstrt	None	81,391	Unemployment Compensation Insurance		22,859	Advertising: Employee Recruitment				
				FICA Taxes		1,354,982	Health Care Worker Background Check (Indicate # of checks performed 140 )		980		
				Employee Health Insurance		1,850,472	NAGNA		4,896		
				Employee Meals			Managed Hlthcare Associates		2,000		
				Illinois Municipal Retirement Fund (IMRF)*		168,380	Deprtr of Professional Regulation		955		
				Accrued Comp -Retention Expense		18,554	Professional Mentoring, LLC		599		
				Employee Srvc Awards		3,868	Amer Society of Consultants		630		
							Various other small amts-per sch		3,838		
							Less: Public Relations Expense	(			
							Non-allowable advertising	(			
							Yellow page advertising	(			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						\$ 180,242	TOTAL (agree to Sch. V, line 20, col. 8)				
B. Administrative - Other							\$ 13,898				
Description				Amount							
Other Contractual Expenses (from County)				\$ 715,981							
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 715,981							
C. Professional Services							G. Schedule of Travel and Seminar**				
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description		Amount		
County Auditor	Acctg & Audit Srvcs		\$ 112,438	N/A		\$	Out-of-State Travel		\$ 2,092		
Strategic Reimbursement, Inc.	Cost Rpt Srvcs		16,760								

**\* Attach copy of IMRF notifications**

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)**

[illegible]

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 229,809 Line 10, Col 2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 278,130  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? YES Indicate the amount. \$ 892,945
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? NONE  
d. Have vehicle usage logs been maintained? YES  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: WOLF & COMPANY, CPA'S The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. Final not yet available.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.